1.0 Description of the Service

A preventive medicine health assessment consists of a comprehensive unclothed physical examination, comprehensive health history, anticipatory guidance/risk factor reduction interventions, and the ordering of gender and age appropriate laboratory and diagnostic procedures.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

The annual health assessment is covered once per year.

4.0 When the Service is Not Covered

The annual health assessment is not covered when the medical criteria listed in **Section 3.0** are not met. The annual health assessment is not covered when the recipient has an illness or specific health care need that results in a definitive medical diagnosis with medical decision-making and the initiation of treatment, and when the policy guidelines listed in **Section 5.0** below are not met.

5.0 Requirements for and Limitations on Coverage

1. Recipients 21 years of age and older may receive one annual health assessment per 365 days.
2. The annual health assessment is included in the legislated 24-visit limit per year.
3. Injectable medications and ancillary studies for laboratory and radiology are the only CPT codes that are separately billable when an annual health assessment is billed.
4. An annual health assessment and an office visit cannot be billed on the same date of service.

6.0 Providers Eligible to Bill for the Service

Physicians, clinics and non-physician practitioners enrolled in the N.C. Medicaid program, functioning within their scope of practice, who perform this service may bill for this service.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

Providers bill professional services on the CMS-1500 (HCFA-1500) claim form.

8.2 Diagnosis Codes that Support Medical Necessity

ICD-9-CM diagnosis code V700, “General medical examination” must be billed.

8.3 Procedure Codes

CPT codes that are covered by N. C. Medicaid include:

- 99385
- 99386
- 99387
- 99395
- 99396
- 99397

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1980

Revision Information:

Date	Section Updated	Change
12/01/03	Section 1.0	The statement that a preventive medicine health assessment includes the ordering of gender appropriate laboratory and diagnostic procedures was revised to read ". . . gender and age appropriate . . ."
12/01/03	Section 4.0	The sentence "The annual health assessment is not covered when the medical criteria listed in Section 3.0 are not met." was added to this section.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/03	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/03	Section 8.0	This section was reformatted into four subsections; there was no change to the content.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
9/1/05	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.